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Wound Assessment

FIG. 1

Pressure Sore Status Tool (PSST)

Circle the appropriate assessment.

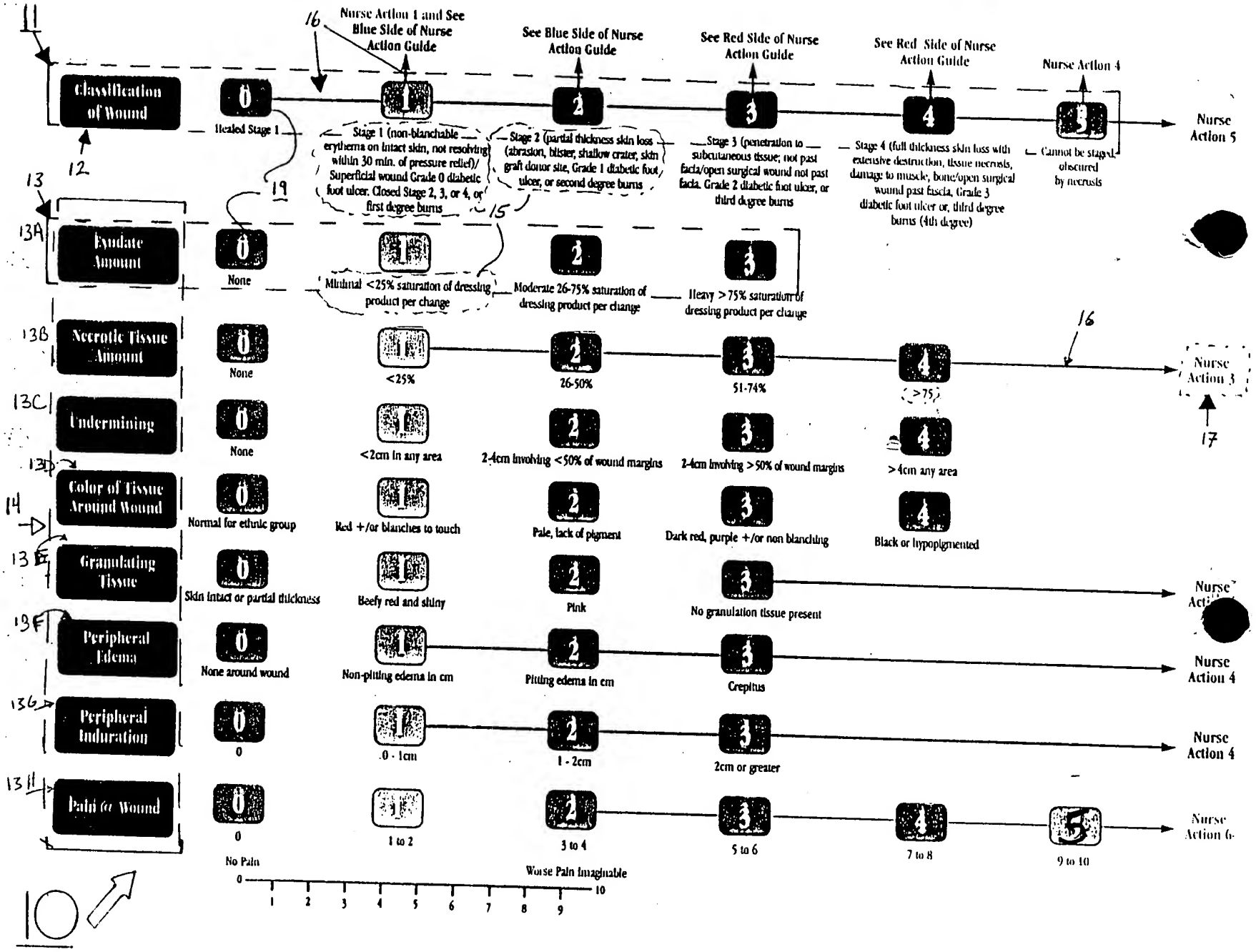


FIG. 2

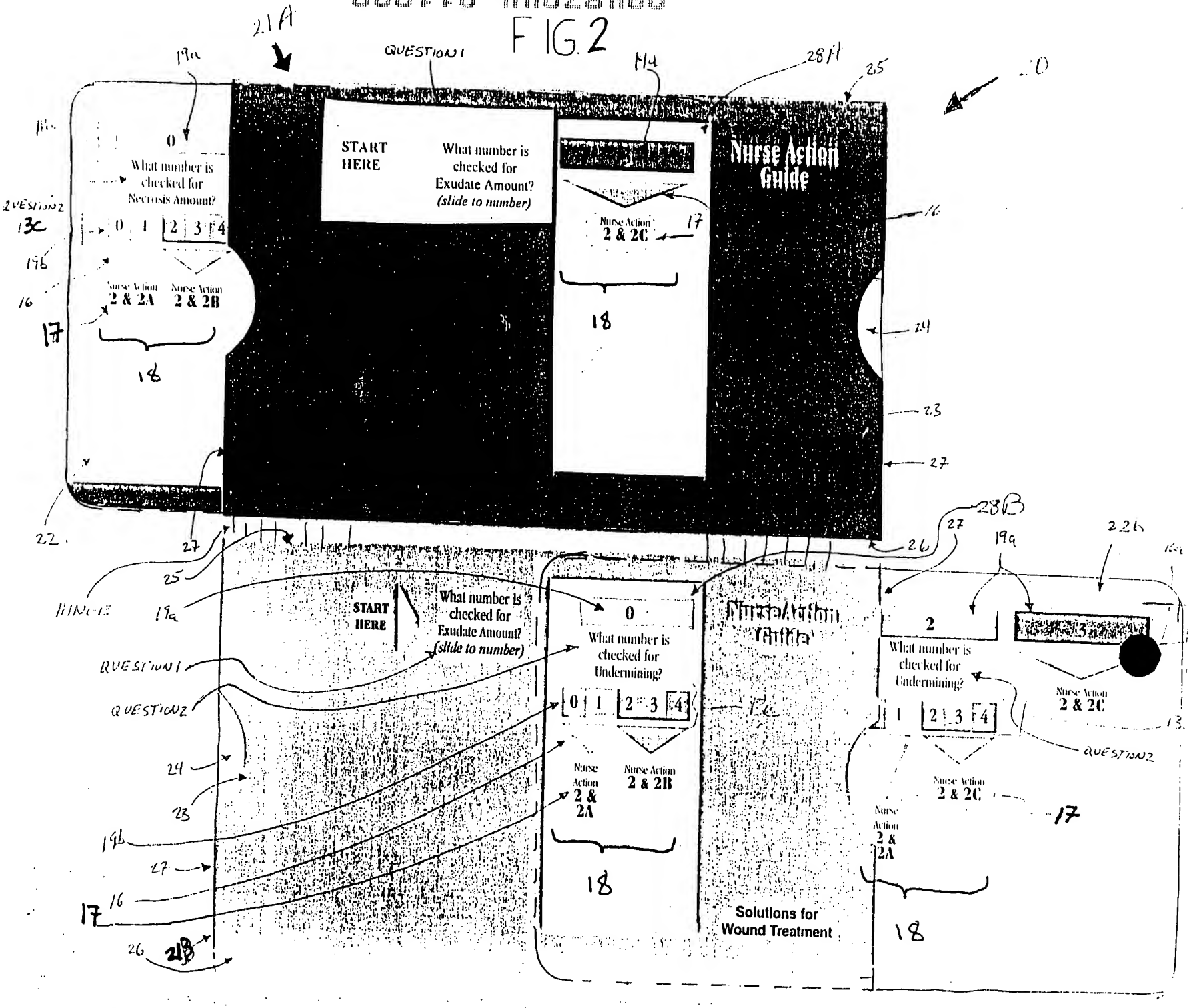
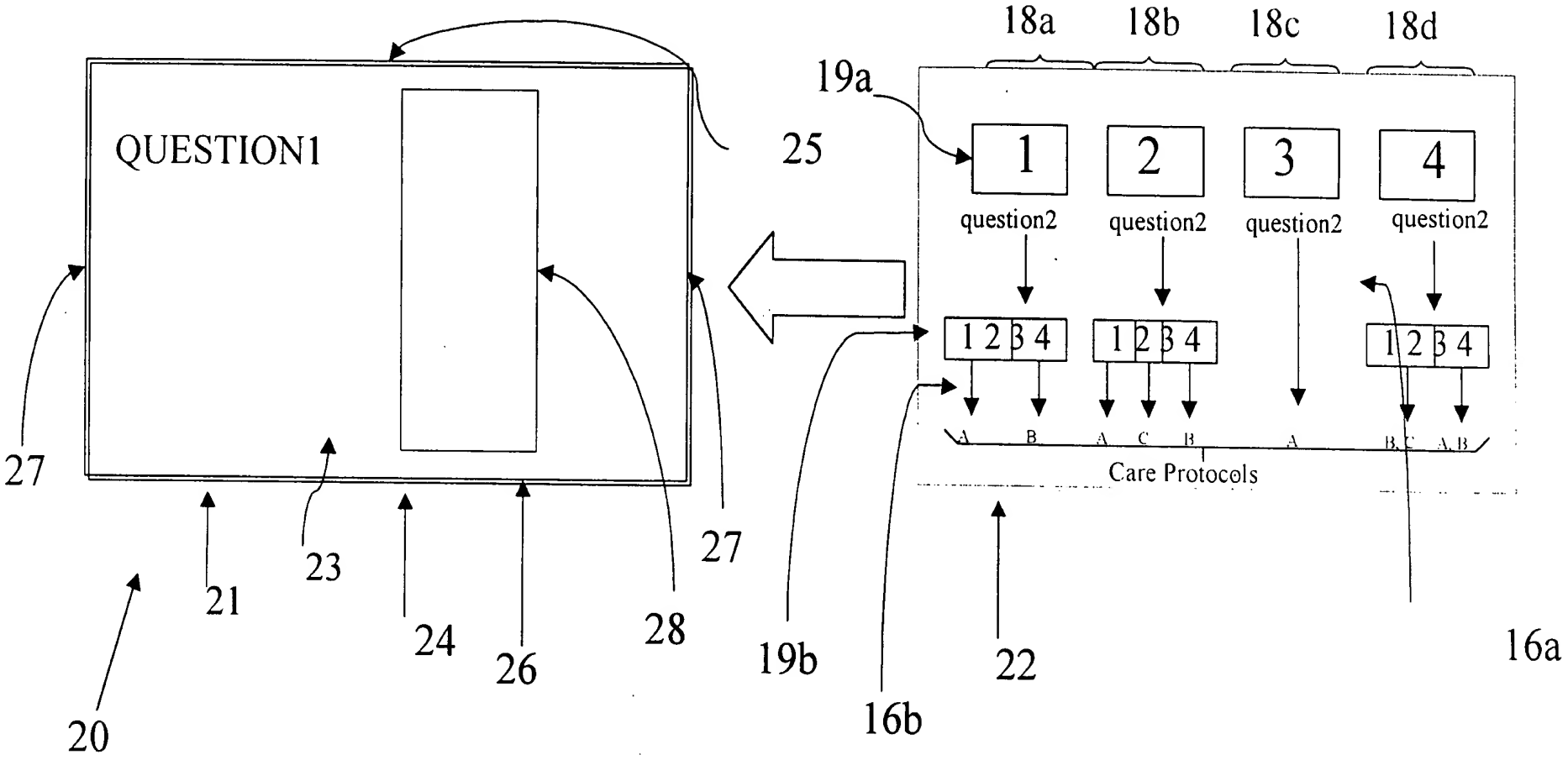


FIG. 2A



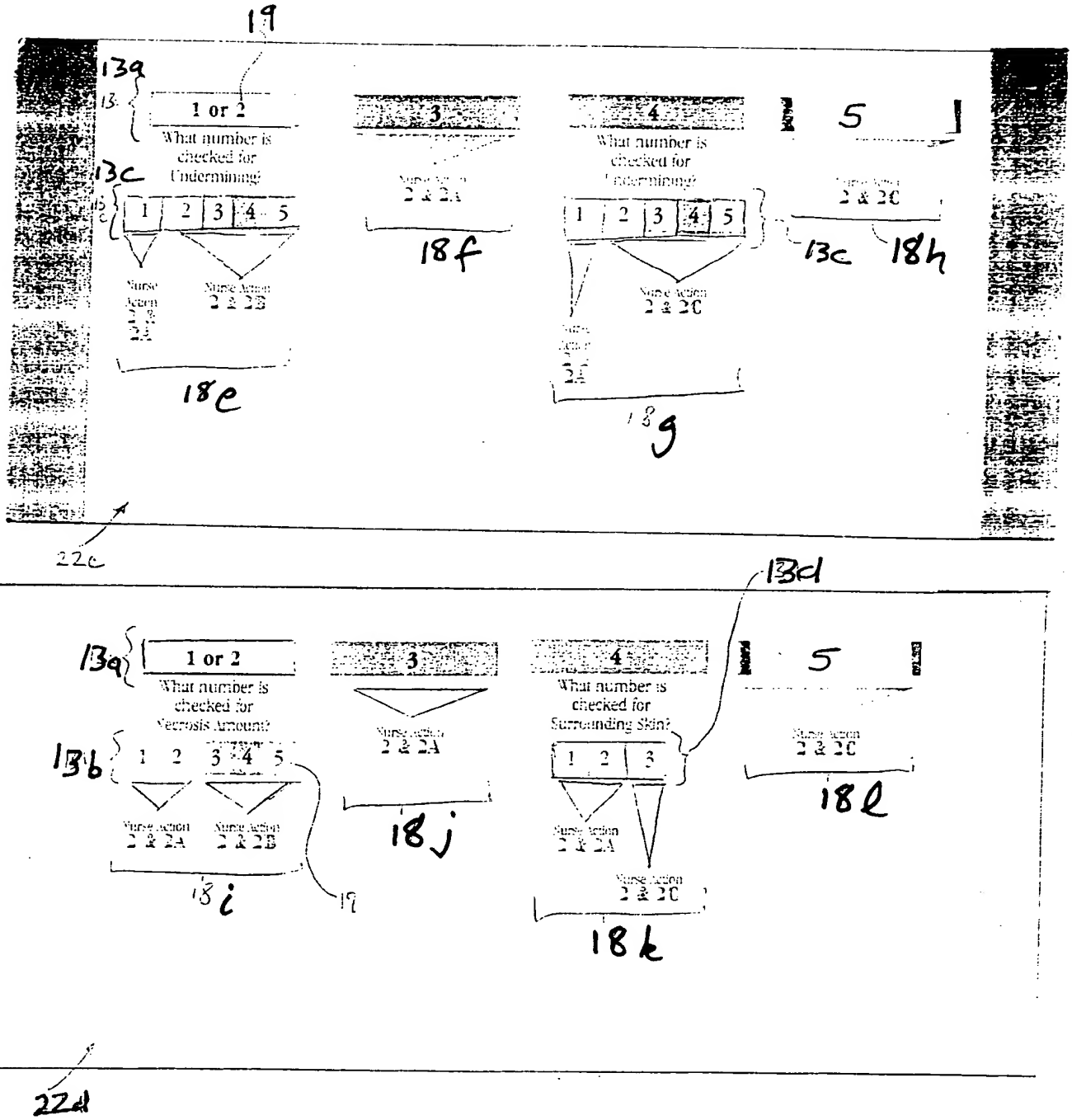

19
13a
1 or 2
What number is checked for Undermining?
1 2 3 4 5
Nurse Action 2 & 2A
Nurse Action 2 & 2B
18e
3
Nurse Action 2 & 2A
18f
4
What number is checked for Undermining?
1 2 3 4 5
Nurse Action 2 & 2C
18g
5
Nurse Action 2 & 2C
13c
18h
22c
13d
13a
1 or 2
What number is checked for Necrosis Amount?
13b
1 2 3 4 5
Nurse Action 2 & 2A
Nurse Action 2 & 2B
18i
19
3
Nurse Action 2 & 2A
18j
4
What number is checked for Surrounding Skin?
1 2 3
Nurse Action 2 & 2A
Nurse Action 2 & 2C
18k
5
Nurse Action 2 & 2C
18l
22d

FIG2B

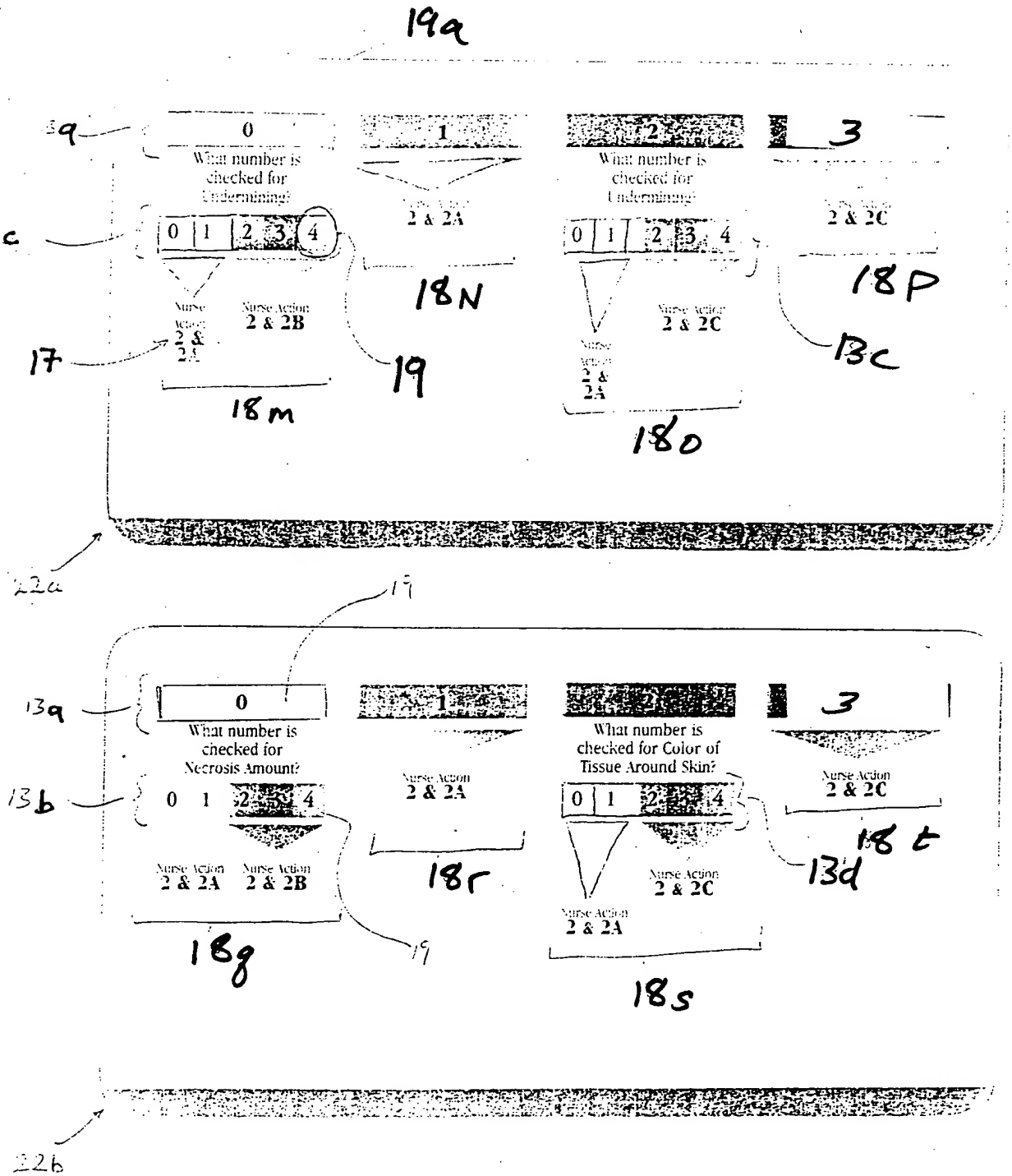
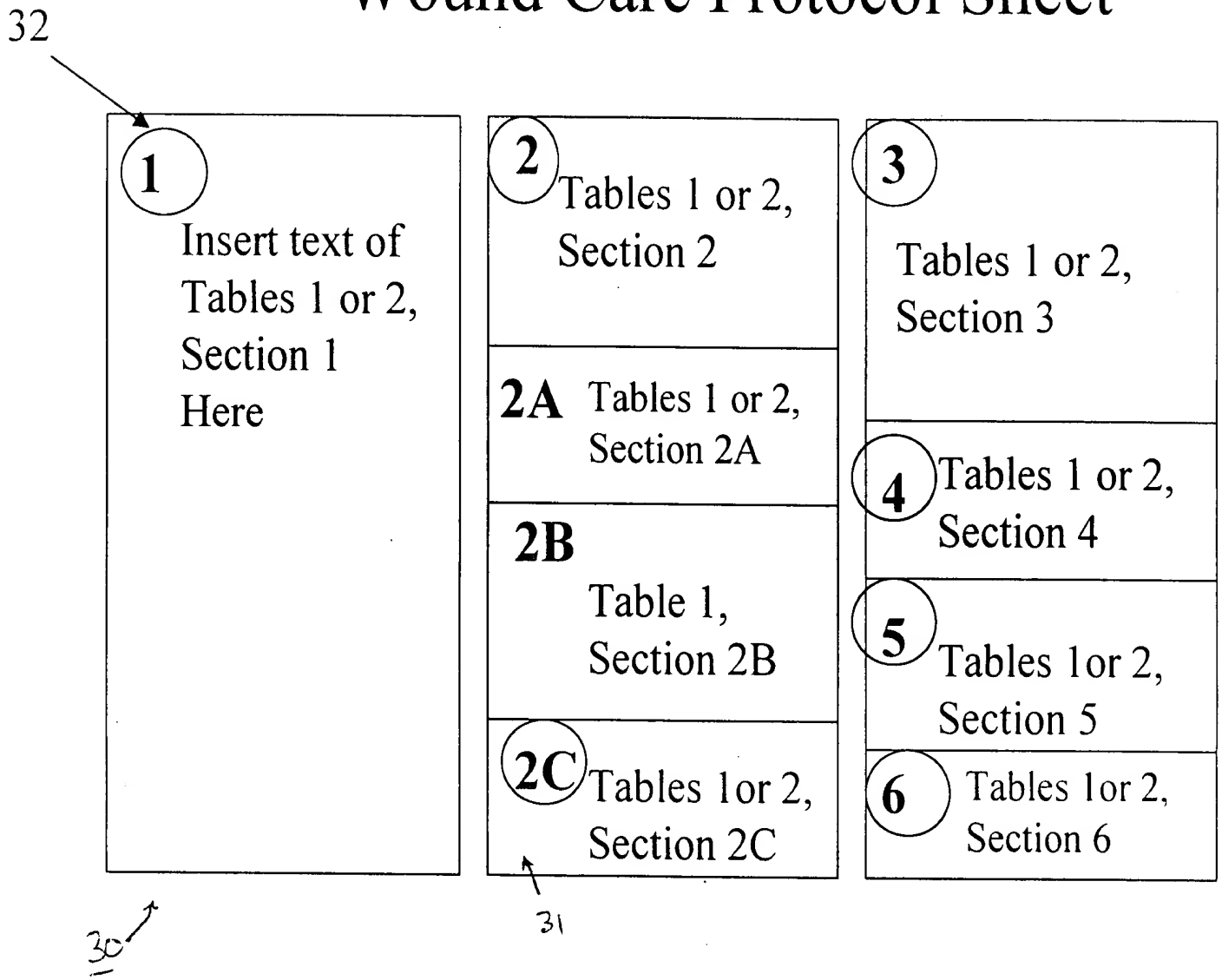

19a
13a
0
What number is checked for Undermining?
0 1 2 3 4
Nurse Action 2 & 2A
Nurse Action 2 & 2B
17
18m
19
1
Nurse Action 2 & 2A
18N
2
What number is checked for Undermining?
0 1 2 3 4
Nurse Action 2 & 2A
Nurse Action 2 & 2C
18o
3
Nurse Action 2 & 2C
18P
13c
22a
19
13a
0
What number is checked for Necrosis Amount?
0 1 2 3 4
Nurse Action 2 & 2A
Nurse Action 2 & 2B
13b
18g
19
1
Nurse Action 2 & 2A
18r
2
What number is checked for Color of Tissue Around Skin?
0 1 2 3 4
Nurse Action 2 & 2C
Nurse Action 2 & 2A
18s
3
Nurse Action 2 & 2C
18t
13d
22b

FIG 2C

FIG. 3
Wound Care Protocol Sheet



Patient Risk Assessment Record

FIG. 4

Braden Scale

Patient ID_____ **Assessment Date**_____ **Clinician**_____

Caregiver Waiter

Circle appropriate assessment

Sensory Perception

Ability to respond meaningfully to pressure-related discomfort

1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment
Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation.	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness.	Responds to verbal commands, but cannot always communicate discomfort or the need to be turned.	Responds to verbal commands, has no sensory deficit which limits the ability to feel pain or voice pain or discomfort.
1b Limited ability to feel pain over most of body surface.	2b Has sensory impairment which limits the ability to feel pain or discomfort over half of the body.	3b Some sensory impairment which limits the ability to feel pain or discomfort in one or two extremities.	

1 2 3 4 | 1b 2b 3b

Moisture

Degree to which skin is exposed to moisture

1. Constantly Moist	2. Very Moist	3. Occasionally Moist	4. Rarely Moist
Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always, moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry, linen only requires changing at routine intervals.

1 2 3 4

See Moisture Chart

Urinary Incontinence ☐ Night ☐ Always

Fecal Incontinence ☐ Formed or semi-formed ☐ Loose or Liquid

Heavy Drainage ☐

Perspiration ☐ Diffuse ☐ Between skin folds ☐ Between skin & mattress

Other _____

Activity

Degree of physical activity

1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently
Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during the day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every two hours during waking hours.

1 2 3 4

See Activity Chart

Mobility

Ability to change and control body position

1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitation
Does not even make slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.

1 2 3 4

See Nutrition Chart

Nutrition

Usual food intake pattern

1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent
Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take liquid dietary supplement.	Rarely eats a complete meal and generally only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take dietary supplement if offered.	Eats over half of most meals. Eats a total of 4 servings of protein (meat or dairy products) per day. Occasionally will refuse a meal, but usually will take a supplement if offered.	Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does require supplementation.
1b Is NIL orally and/or maintained on clear liquids or IV's for more than 5 days.	2b Gets less than optimum amount of liquid diet or tube feeding.	3b Is on tube feeding or TPN regime which probably meets most nutritional needs.	Intake Type ☐ Oral ☐ Enteral ☐ Parenteral

1 2 3 4 | 1b 2b 3b

Friction & Shear

1. Problem	2. Potential Problem	3. No Apparent Problem
Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, require frequent repositions with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against the sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.

1 2 3

See Friction & Shear Chart

TOTAL

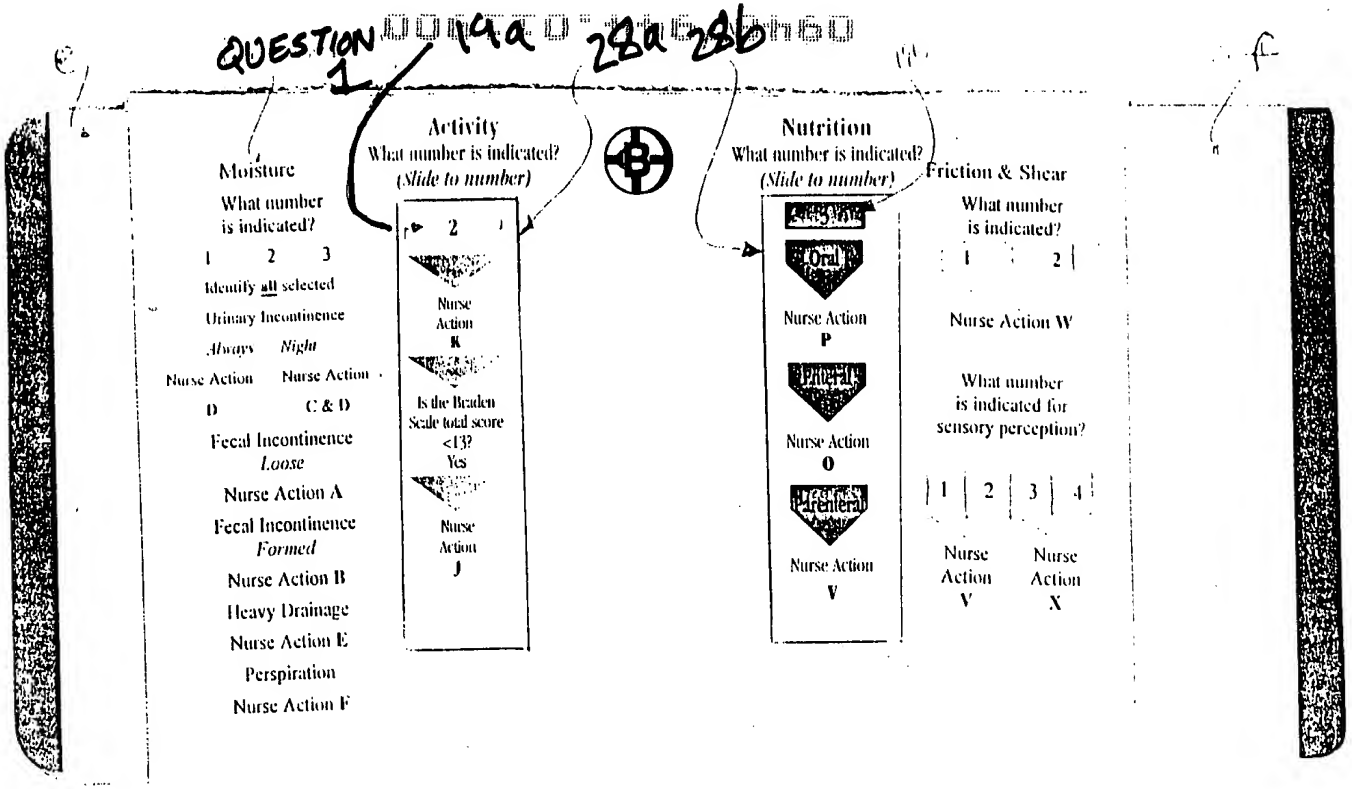
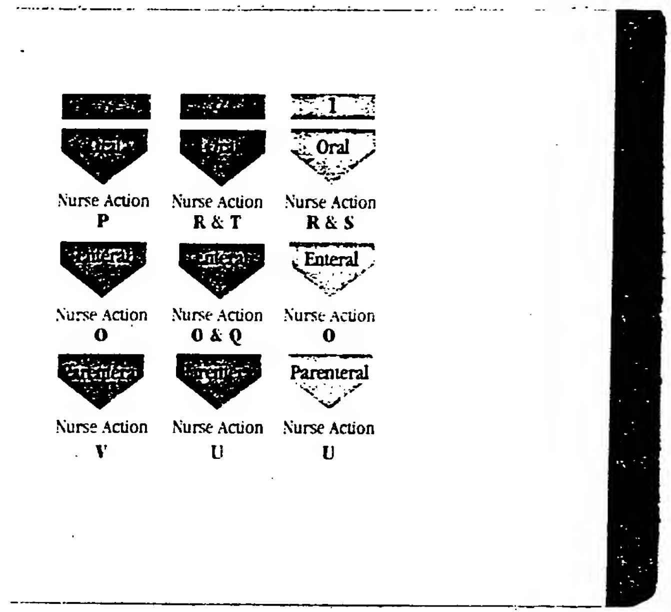

QUESTION 1
19a
28a
28b
Moisture
What number is indicated?
1 2 3
Identify all selected
Urinary Incontinence
Always
Night
Nurse Action D
Nurse Action C & D
Fecal Incontinence
Loose
Nurse Action A
Fecal Incontinence
Formed
Nurse Action B
Heavy Drainage
Nurse Action E
Perspiration
Nurse Action F
Activity
What number is indicated? (Slide to number)
2
Nurse Action K
Is the Braden Scale total score <13?
Yes
Nurse Action J
Nutrition
What number is indicated? (Slide to number)
Oral
Nurse Action P
Enteral
Nurse Action O
Parenteral
Nurse Action V
Friction & Shear
What number is indicated?
1 2
Nurse Action W
What number is indicated for sensory perception?
1 2 3 4
Nurse Action V
Nurse Action X

FIG. 5

22f



22e

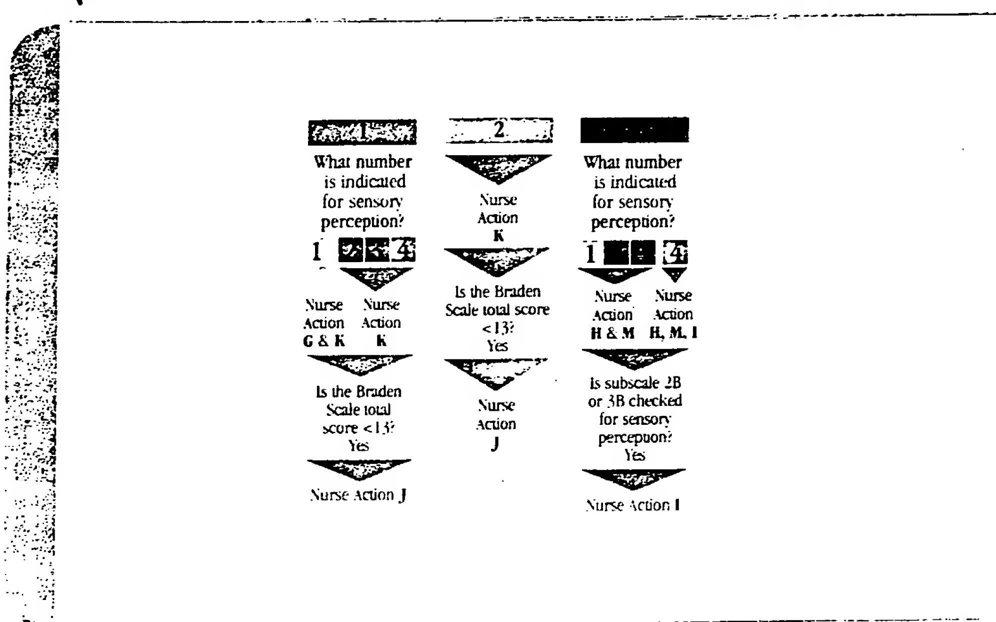

What number
is indicated
for sensory
perception?
1
4
Nurse
Action
G & K
Nurse
Action
K
Is the Braden
Scale total
score <13?
Yes
Nurse Action J
2
Nurse
Action
K
Is the Braden
Scale total score
<13?
Yes
Nurse
Action
J
What number
is indicated
for sensory
perception?
1
4
Nurse
Action
H & M
Nurse
Action
H, M, I
Is subscale 2B
or 3B checked
for sensory
perception?
Yes
Nurse Action I

FIG. 5B

FIG. 6
Nurse Action Report Sheet

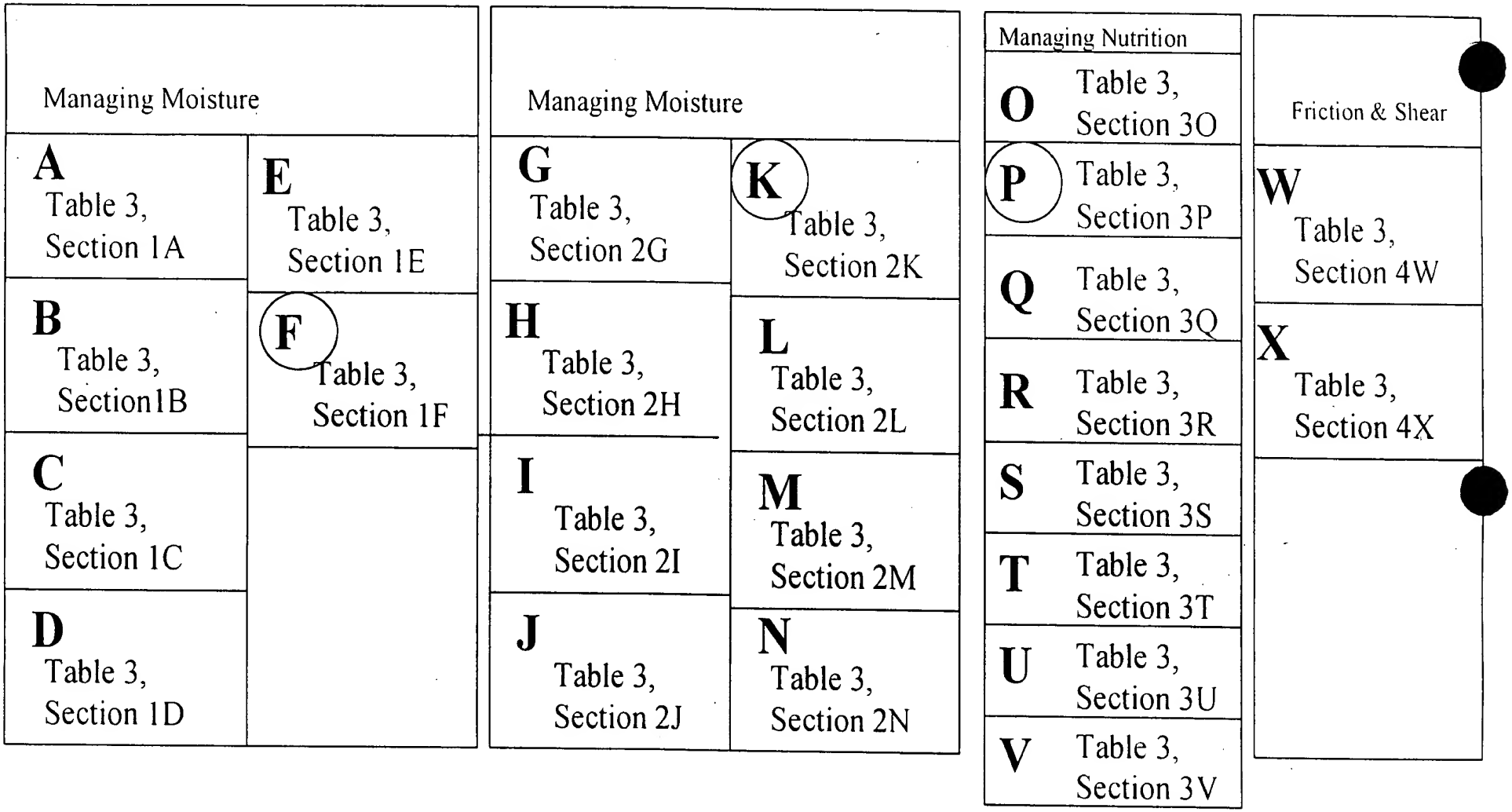


FIG. 7

Wound Care Assessment Record

Name_____

Date of Birth_____Admission Date:_____

Discharge Date:_____

Patient ID_____Assessment Date_____

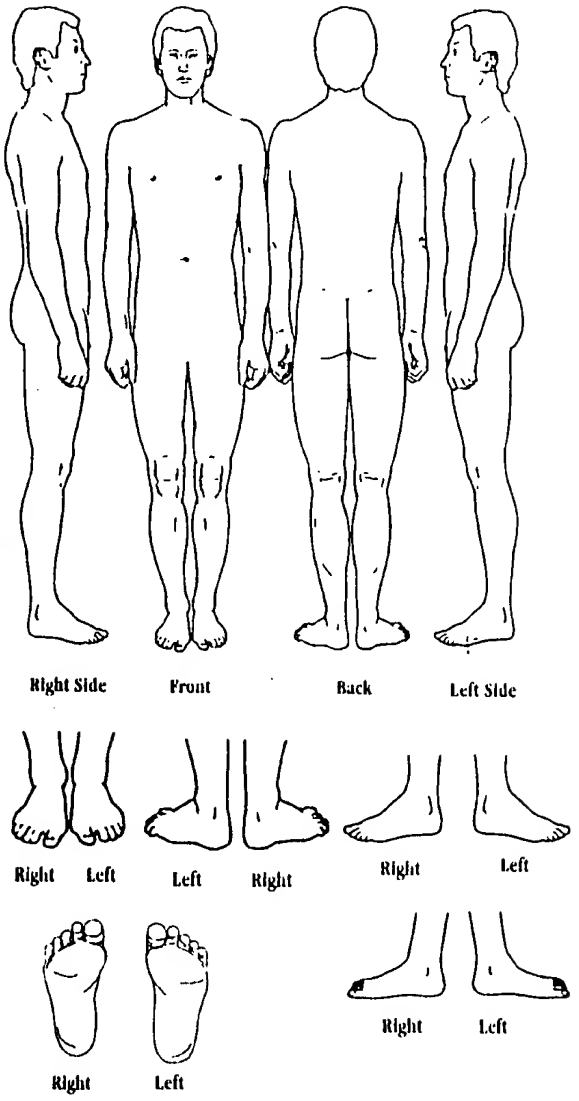
Existing Wound ☐ Ulcer #_____

New Wound ☐ Give Ulcer #_____

Clinician_____

Caregiver/Writer

Indicate Area



Indicate Type

Wound Type

- ☐ Arterial/Ischemic Ulcer
- ☐ Burn
- ☐ Neuropathic Ulcer
- ☐ Perineal
- ☐ Dermatitis
- ☐ Pressure Ulcer
- ☐ Rash
- ☐ Skin Tear
- ☐ Surgical Wound
- ☐ Venous Ulcer
- ☐ Other_____

Indicate Size

Measurements

Length = Longest Axis

Length_____cm
Width _____cm
Depth _____cm

Butterfly Only

Length_____cm
Width _____cm
Length_____cm
Width _____cm
Depth _____cm

WSIS Bedside Companion

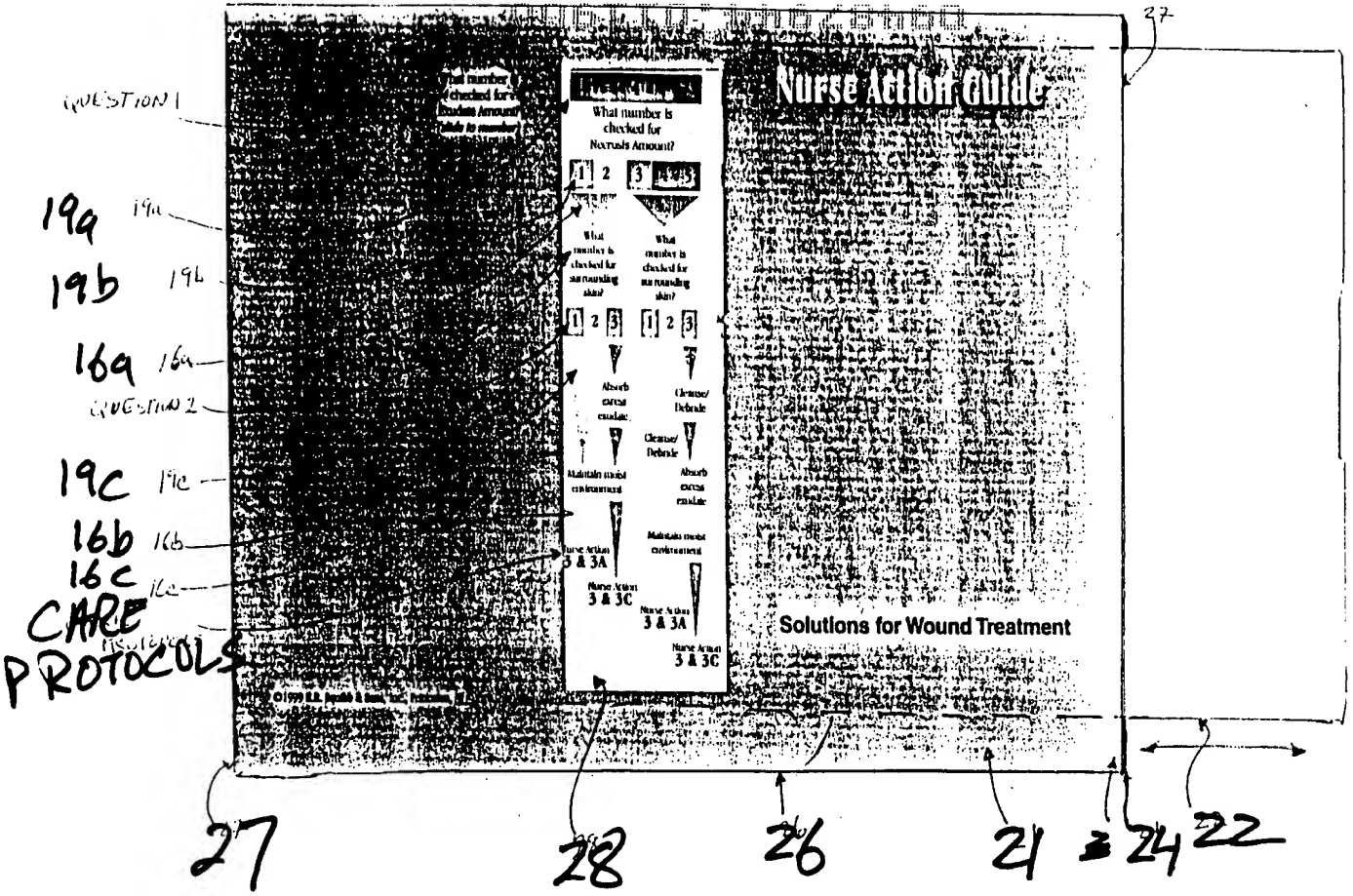

Nurse Action Guide
What number is checked for Nexrusis Amount?
Solutions for Wound Treatment
QUESTION 1
19a
19b
16a
QUESTION 2
19c
16b
16c
CARE PROTOCOLS
27
28
26
21
24
22

FIG. 8

Wound Assessment

Circle the appropriate assessment.

FIG. 9

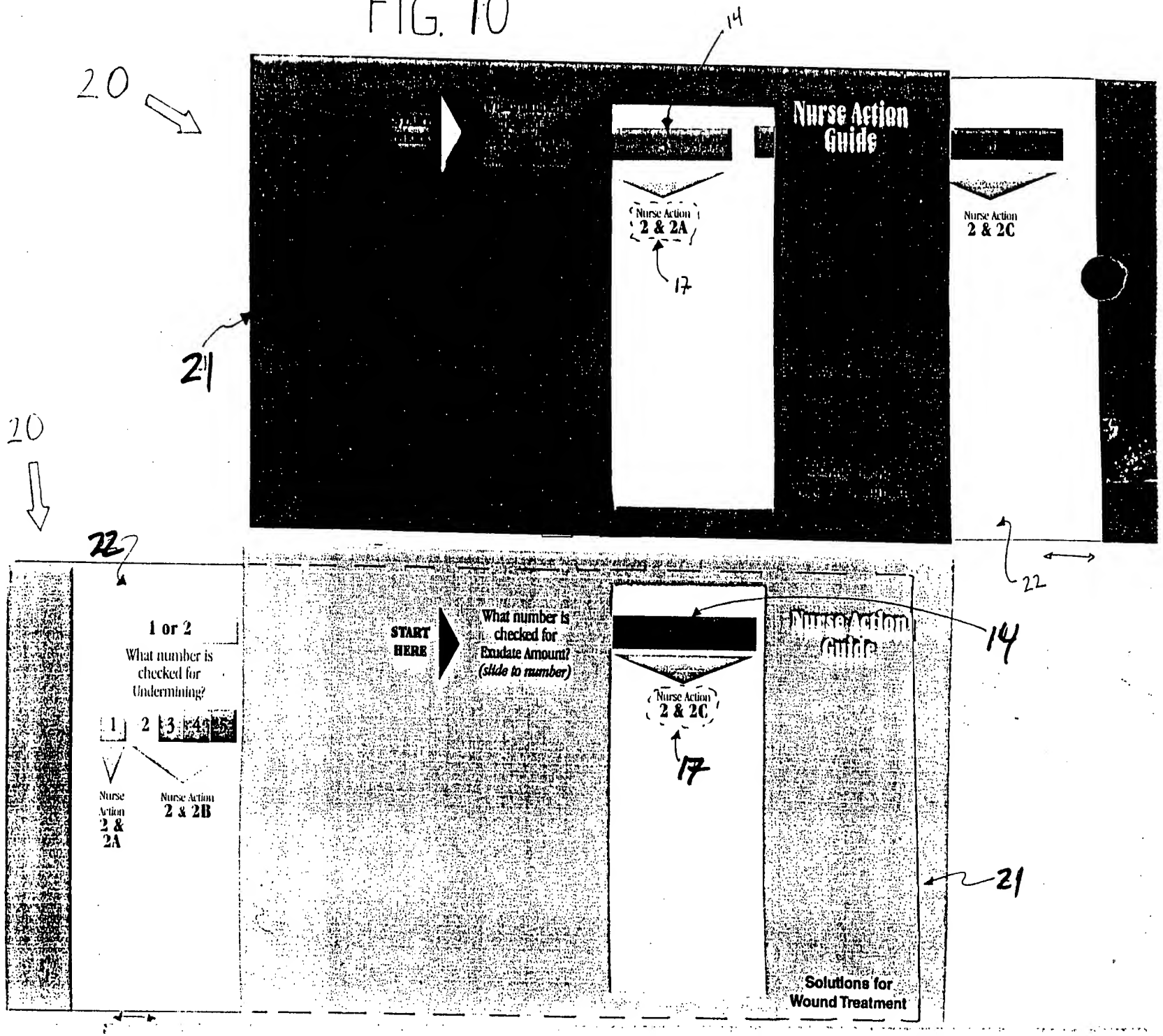
	Nurse Action 1 and See Blue Side of Nurse Action Guide	See Blue Side of Nurse Action Guide	See Red Side of Nurse Action Guide	Nurse Action 2	See Red Side of Nurse Action Guide
Depth	1 Non-blanchable erythema on intact skin	Partial thickness involving epidermis &/or dermis	3 Full thickness, damage/necrosis of subcutaneous tissue/ may extend down to fascia; &/or mixed partial/full-thickness; obscured by granulation tissue	4 Obscured by necrosis	5 Full thickness with extensive destruction
Exudate Amount	1 None	Scant	3 Small	4 Moderate	5 Large
Exudate Type	1 None or bloody	2 Serosanguineous thin, watery, pale red/pink	3 Serous: thin, watery, clear	4 Purulent: thin or thick, opaque, tan /yellow	5 Foul purulent: thick, opaque, yellow/green with odor
Necrotic Tissue Amount	1 None visible	<25% wound bed covered	3 25-50% wound covered	4 >50% <75% wound covered	5 75-100% wound covered → Nurse Action 4
Necrotic Tissue Type	1 None visible	2 White/gray or non-adherent yellow slough	3 Loosely adherent yellow slough	4 Adherent, soft black eschar	5 Firmly adherent, hard black eschar
Undermining	1 <2cm in any area	2-4cm <50% of wound margins	3 2-4cm >50% of wound margins	4 >4cm in any area	5 Tunneling or sinus tract infection
Surrounding Skin Color	1 Pink or normal for ethnic group	Bright red &/or blanches to touch	3 White or gray pallor or hypopigmented	4 Dark red or purple &/or non-blanchable	5 Black or hypopigmented → Nurse Action 6
Granulation	1 Skin intact or partial thickness	Bright, beefy red 75%-100% wound filled	3 Bright, beefy red <75% & >25% wound filled	4 Pink/dull dusty red &/or fills ≤ 25%	5 No granulation present → Nurse Action 5 & 6

	Nurse Action 6				
Peripheral Edema	1 Minimal swelling around wound	No pitting <4cm around wound	3 No pitting ≥ 4cm around wound	4 Pitting <4cm around wound	5 Crepitus/ pitting ≥ 4cm → Nurse Action 5 & 6
Peripheral Induration	1 Minimal firmness around wound	<2cm around wound	3 2-4cm <50% around wound	4 2-4cm >50% around wound	5 >4cm in any area → Nurse Action 5 & 6
Pain @ Wound	1 No response 0	No verbal 1-3	3 Minimal 4-6	4 Moderate 7-9	5 Severe pain 10 → Nurse Action 6 & 7
Nutrition	1 Normal	75%	3 50%	4 Poor <50%	5 Tube or poor oral → Nurse Action 8
Infection	1 Erythema	2 Excessive Exudate	3 Increase temp at site	4 Induration	5 Infection confirmed
Edges	1 Indistinct, diffuse, none visible	2 Distinct, outline visible, attached, even with base	3 Well defined not attached to base	4 Well defined, not attached, rolled under, thickened	5 Well defined, fibrotic, scarred, or hyperkeratotic
Epithelialization	1 100% covered, skin intact	2 75-100% covered &/or extends >.5cm into wound bed	3 50-75% covered &/or extends to <.5cm into wound bed	4 25-50% covered	5 <25% covered
Functional Ability	1 Normal	2 Slight change	3 50%	4 <50%	5 <25%
Compliance	1 Motivated 100%	2 Motivated 75%	3 Motivated <75%	4 Motivated 50%	5 Motivated 25%
Healthy Margin	2cm ☐ Yes ☐ No				

How much time spent on assessment?

____ Minutes

FIG. 10


20
14
Nurse Action Guide
Nurse Action 2 & 2A
17
Nurse Action 2 & 2C
21
20
22
1 or 2
What number is checked for Undermining?
1
2
3
4
5
Nurse Action 2 & 2A
Nurse Action 2 & 2B
START HERE
What number is checked for Exudate Amount? (slide to number)
Nurse Action 2 & 2C
17
14
Nurse Action Guide
21
Solutions for Wound Treatment
22

Patient ID____________________

Assessment Date________________

Add New Wound________________

Clinician____________________

Caregiver/Writer

Ulcer #____________________

Existing Wound________________

Status
- ❑ Active
- ❑ Healed

Wound Type
- ❑ Arterial/Ischemic Ulcer
- ❑ Burn
- ❑ Neuropathic Ulcer
- ❑ Perineal
- ❑ Dermatitis
- ❑ Pressure Ulcer
- ❑ Rash
- ❑ Skin Tear
- ❑ Surgical Wound
- ❑ Venous Ulcer
- ❑ Arterial/Ischemic Ulcer
- ❑ Other__________

Wound Stage
- ❑ Stage I
- ❑ Stage II
- ❑ Stage III
- ❑ Stage IV
- ❑ Unable to stage
- ❑ N/A

Wound Site
- ❑ Ankle
- ❑ Back of Head
- ❑ Coccyx
- ❑ Ear
- ❑ Elbow
- ❑ Forearm
- ❑ Heel
- ❑ Iliac Crest
- ❑ Ischial Tuberosity
- ❑ Knee
- ❑ Lower Leg
- ❑ Sacrum
- ❑ Scapula
- ❑ Thigh
- ❑ Toe(s)
- ❑ Trochanter
- ❑ Vertebrae
- ❑ Other________

Wound Shape
- ❑ Butterfly
- ❑ Irregular
- ❑ Linear/Elongated
- ❑ Oval
- ❑ Square
- ❑ Round
- ❑ Rectangle

Measurements

Length = Longest Axis

Length______cm
Width ______cm
Depth ______cm

Butterfly Only

Length______cm
Width ______cm
Length______cm
Width ______cm
Depth ______cm

Wound Placement
- ❑ Left
- ❑ Right
- ❑ N/A

- ❑ Anterior
- ❑ Anterolateral
- ❑ Inferior
- ❑ Lateral
- ❑ Medial
- ❑ Posterior
- ❑ Other________

Factors Delaying Wound Healing

Blood Related
- ❑ Anemia of any sort
- ❑ Compromised vascular tree (arterial, venous)

Malnutrition
- ❑ Albumin <3.0g/dl

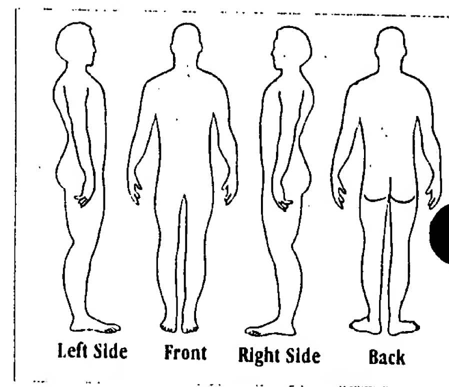
Deficiencies in:
- ❑ Iron
- ❑ Protein
- ❑ Vitamin A
- ❑ Vitamin C
- ❑ Water
- ❑ Zinc

Metabolic Disorders
- ❑ Diabetes
- ❑ Thalasemia

Other
- ❑ Radiation Therapy/ Cytotoxic Drugs
- ❑ Smoking
- ❑ Stress
- ❑ Steroids/Anti-Inflammatory Medications
- ❑ Surgery

Current Primary Diagnosis

____



Indicate proper area

WSIS

- FIG.11 -

CV283, drawing elements

10 Interactive visual scoring sheet
- first defined scale **11**
- first wound factor **12**
- second defined scale **13**
- second wound factors **14**
- criteria **15** pertaining to wound or patient classification
- connecting indicia **16**
- treatment protocols **17**
- visual decision tree **18**
- markers **19**

20 Visual Decision Tree Device
- housing **21**
- sliding card **22**
- top layer **23**
- bottom layer **24**
- top edge **25**
- bottom edge **26**
- side edge **27**
- view window **28**
- first question **QUESTION1**
- first set of markers **19a**
- first set of arrows **16a**
- a second set of markers **19b**
- second question **QUESTION2**
- second set of arrows **16b**.

30 Wound care protocol sheet
- module **31**

40 Patient data sheet